Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: CORAZON . RAMIREZ,MD 9080 HARRY HINES, STE. 110 DALLAS, TX 75235	MFDR Tracking #: M4-09-8054-01
Respondent Name and Box #: AMERISURE MUTUAL INSURANCE CO. Rep Box # 47	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Insurance Carrier paid incorrect allowable on claim. Our recon was denied with no further explanation. The correct payment for a non medically directed CRNA should be 100% of the calculated allowable!"

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $167.82
3. CMS 1500
4. EOB's

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "00630-QZ was reimbursed according to DWC MAR in the amount of $670.59 based on the following calculation: 118 minutes billed by HCP = 7.8667 time unit + ASA base unit = 8 for a total of 15.8667 units X ASA calculation 2008 = $52.83 $838.24 X 80% for the CRNA without Direction Modifier QA for a total of $670.59…CRNA REIMBURSEMENT…Services furnished by qualified anesthetist are subject to the Part B deductible and coinsurance. If the Part B deductible has been satisfied, payment is based on 80 percent of the actual charge or 80 percent of the allowable amount utilizing the anesthesia calculation, whichever is lower."

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
7/31/08	00630-QZ (See Calculations Below)	W1, R, W4	1-6	$167.82
Total /Due:				$167.82

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied or reduced payment by the Respondent with reason codes:
   - "W1-Workers Compensation State Fee Schedule Adjustment;
   - R-(Paid Service Code) – Service is the result of a review for payment eligibility; and
   - W4-No additional reimbursement allowed after review of appeal/reconsideration."
2. Based upon the submitted CMS-1500 the anesthesiology time billed was 118 minutes.
3. The Requestor billed 00630-QZ for "Anesthesia for spine, cord surgery." The QZ modifier designates that the anesthesia was administered by CRNA and was not medically directed. Per Rule 134.203, CPT code 00630-QZ has a base unit of 8.
4. Per Rule 134.203(c)(1), the DWC conversion factor for professional services provided in a facility or an ASC by a physician is $66.32.
5. Per 28 Texas Administrative Code Section 134.203(b), the MAR for CPT code 00630-QZ is:
   - Time units = 118 divided by 15 minute increment = 7.87 units
   - Base units = 8 units
   - 7.87 units + 8 units = 15.87 units
   - 15.87 units x $66.32 (conversion factor) = $1,052.50
   - $1,052.50 – $670.59 amount paid by insurance carrier = $381.91

The Requestor is seeking a lesser amount of $167.82, this amount is recommended for reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, 134.203
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $167.82 plus applicable accrued interest per Division Rule 134.130.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	August 5, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.